STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075286	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Newington	240 Church St Newington, CT 06111

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, facility documentation and policies for one (1) of three (3) residents (Residents #1) reviewed for abuse, the facility failed to ensure the Resident Care Plan (RCP) was updated following a room change for a severity cognitively impaired resident with adjustment disorder, when the resident was moved from a room on the secured unit to a room on the non-secured unit after a resident-to-resident physical altercation. The findings included:Resident #1 was admitted to the facility in March of 2023 and had diagnoses which included dementia, schizoaffective disorder, depressive type, and adjustment disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 as severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 00), was dependent with bathing, required substantial assistance with toileting and personal hygiene, and was able to ambulate with supervision/touch assistance.The RCP dated 8/16/25 identified Resident #1 received psychotropic medication related to the diagnosis of dementia, depression, schizoaffective disorder, anxiety, and insomnia, and a history of refusal of care, paranoia/delusions, and hitting, and that he/she was a resident with a dementia diagnosis in a secured memory care unit related to behaviors that required staff intervention and redirection for safety as well as life enriching specialized dementia program. Interventions directed to monitor for depression as evidenced by refusal of care, hitting staff, paranoia, and delusions, and intervene and redirect when wandering, exit seeking, or when behaviors become intrusive or affect other residents. The Reportable Event Form dated 10/11/25 identified Resident #5 was struck in the face by another resident (Resident #1), and mild swelling was noted to the left of Resident #5's face.A nurse's note by the Assistant Director of Nurses on 10/12/25 at 12:05 PM identified Resident #1 continued with a one-to-one (staff assigned monitor) and appeared to be adjusting to the room change, had no complaints of pain or discomfort, and to continue with the plan of care.Interview with the Director of Nursing Services on 4/16/26 at 4:10 PM identified Resident #1 was moved from the secured unit to the non-secured unit on 10/11/25 following an incident with Resident #5. Review of the RCP failed to identify revisions following the move from a secured unit to a non-secured unit on 10/11/2025.Interview with SW #1 on 4/17/26 at 2:54 PM identified the interdisciplinary team (IDT) would typically meet to discuss resident's needs and develop a plan of care prior to changing a room. However, if the resident was moved due to a safety concern, the IDT would convene as soon as practicable thereafter, which did not occur for Resident #1.The Comprehensive Care Planning policy directed a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs were developed and implemented for each resident and that care plan interventions were chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between resident's problem areas and their causes, and relevant clinical decision making.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, facility documentation and policies for one (1) of three (3) residents (Residents #1) reviewed for abuse, the facility failed to ensure a resident involved in a physical altercation received a harm clearance prior to returning to the facility. The findings included: Resident #1 was admitted to the facility in March 2023 and had diagnoses which included dementia, schizoaffective disorder, depressive type, and adjustment disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 as severely cognitively impaired (Brief Mental Interview for Mental Status (BIMS) of 4), was dependent with toileting and lower body dressing, and was able to ambulate fifty (50) feet with moderate assistance. The Resident Care Plan (RCP) dated 1/31/26 identified Resident #1 received psychotropic medication related to the diagnosis of dementia, depression, schizoaffective disorder, anxiety, and insomnia, and a history of refusal of care, paranoia/delusions, and hitting, and resident to resident altercations. Interventions directed to monitor for depression as evidenced by refusal of care, hitting staff, paranoia, and delusions, a room change, and to keep the resident in visible area when out of bed.Review of facility documents dated 3/16/26 at 1:10 PM identified an unwitnessed incident between Resident #1 and Resident #2. Resident #2 reported being struck by another resident (Resident #1), then pushed the resident (Resident #1), causing him/her to fall. Resident #2 was placed with a one-to-one (continuous monitoring) and sent to the hospital for a psychiatric evaluation. However, Resident #1, observed lying on the floor, reported he/she was struck in the face by another resident and sustained a laceration to his/her right eyebrow. Resident #1 was placed with a one-to-one (continuous monitoring) with a request for a psychiatric consult. Review of APRN #1's note dated 3/16/26 at 3:48 PM identified Resident #1 was evaluated following a fall for a right eye laceration and agitation/pushing with another resident and recommended his/her transfer to the emergency department for evaluation.The hospital Discharge summary dated [DATE] identified Resident #1 sustained a laceration to the right eye and a closed fracture of the right maxillary sinus, however failed to indicate Resident #1 had received a psychiatric evaluation while at the hospital.A nurse's note by RN #2 on 3/17/26 at 12:54 AM identified Resident #1 returned to facility at 11:30 PM from a hospital evaluation.Review of facility documentation failed to identify a no harm letter was received for Resident #1 regarding the 3/16/26 resident-to-resident altercation. A nurse's note by APRN #2 on 3/17/26 at 7:25 AM identified Resident #1 was evaluated following the 3/16/26 altercation and was not considered a danger to self or others. However, this evaluation occurred seven (7) hours and fifty-five (55) minutes after Resident #1 was re-admitted to the facility.Interview with the Director of Nursing Services (DNS) on 4/16/26 at 4:10 PM identified although the facility identified both Resident #1 and Resident #2 were sent to the hospital to receive both medical and psychiatric evaluations, it was the hospital's providers that deemed Resident #1's concerns were trauma related versus psychiatric. The DNS identified the facility did have Resident #1 evaluated by a psychiatric provider on 3/17/26 at 7:25 AM, who indicated Resident #1 was not a risk to his/herself or other residents, and indicated normal rounding practices and staffs' awareness to monitor Resident #1 following the 3/16/26 altercation was sufficient to ensure residents at the facility were safe.Interview with the Regional Clinical Support Nurse (RCSN) on 4/17/26 at 2:18 PM identified the registered nurse readmitting the resident into the facility after being evaluated at the hospital for an altercation was responsible to review the hospital discharge paperwork, and if documentation was missing, the nurse was to notify the provider of the missing documentation to ensure the safety of the resident(s). The RCSN further indicated that the hospital's failure to complete the psychiatric evaluation should have resulted in a phone call to psychiatric provider/provider to obtain clearance for the patient's return, or to assign a one-to one monitor until clearance was obtained.Although requested, the facility did not have a policy specific to psychiatric evaluations/one-to-one assignments for residents involved in physical altercations.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation/policies, and interviews, for one (1) of three (3) sampled residents (Resident #1) reviewed for accidents, the facility failed to ensure adequate supervision and develop a plan to maintain the resident's safety during a scheduled room maintenance activity that required removal from his/her room. Resident #1 had known aggressive behaviors and preferred to remain in his/her room; however, when displaced into a common area without an established supervision plan, the resident was not adequately monitored and entered another resident's room, resulting in a resident-to-resident altercation with injury. The findings included:1a. Resident #1 was admitted to the facility in March of 2023 and had diagnoses which included dementia, schizoaffective disorder, depressive type, and adjustment disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 as severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 4), dependent with toileting and lower body dressing, and was able to ambulate fifty (50) feet with moderate assistance. The Resident Care Plan (RCP) dated 1/31/26 identified Resident #1 received psychotropic medication related to the diagnosis of dementia, depression, schizoaffective disorder, anxiety, and insomnia, and a history of refusal of care, paranoia/delusions, and hitting, and resident to resident altercations. Interventions directed to monitor for depression as evidenced by refusal of care, hitting staff, paranoia, and delusions, a room change, and to keep the resident in visible area when out of bed.b. Resident #2 was admitted to the facility in March of 2023 and had diagnoses which included disorganized schizophrenia, schizoaffective disorder, unspecified, and generalized anxiety disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 as moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 12) and was independent with all activities of daily living. The Resident Care Plan (RCP) dated 1/31/26 identified Resident #2 was at risk for adverse effects related to use of medication and for mood and behavior, as evidenced by agitation, yelling, emotional, and fidgeting. Interventions directed to monitor for changes in mood and behavior, update the provider as necessary, and ensure a quiet environment so the resident can work on self-calming techniques when feeling worked up or anxious. A Reportable Event (RE) form dated 3/16/26 at 1:10 PM identified Resident #2 reported being struck by another resident (Resident #1), and then pushed the resident (Resident #1), causing him/her to fall. Resident #2 was sent to the hospital for a psychological evaluation.An RE form dated 3/16/26 at 1:10 PM identified Resident #1 was observed lying on the floor of Resident #2's room, stating he/she was struck in the face by another resident and sustained a laceration to his/her right eyebrow. Resident #1 was placed on a one-to-one (assigned monitoring) and psyche consult. The hospital Discharge summary dated [DATE] identified Resident #2 did not demonstrate agitated or aggressive behaviors, remained in behavioral control, was compliant with care, and was discharged back to the nursing facility with a no harm letter.The hospital Discharge summary dated [DATE] identified Resident #1 sustained a laceration to the right eye and a closed fracture of the right maxillary sinus, however, did not receive a psychological evaluation while at the hospital.Interview with LPN #3 (assigned to Resident #1 during the 7:00 AM to 3:00 PM shift on 3/16/26) on 4/15/26 at 1:31 PM identified the facility was performing a thorough cleaning of Resident #1's room on 3/16/26, requiring him/her to be moved from his room into the hallway while cleaning took place and Resident #1 was monitored by NAs assigned to that wing. LPN #3 indicated an NA heard commotion in Resident 2's room and found Resident #1 on the floor bleeding. LPN #3 further indicated the two residents were separated immediately, the nursing supervisor, Director of Nursing Services and provider were informed, Resident #1 was assisted back to his/her chair and 911 was called. LPN #3 identified during the time of the incident, NAs were passing out lunch trays and LPN #3 was performing blood glucose monitoring and unable to monitor Resident #1 during that time. LPN #3 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	further indicated Resident #1 preferred to stay in his/her room. Interview with the Director of Housekeeping (DOH) on 4/16/26 at 9:35 AM identified Resident #1's floors were stripped and walls washed on 3/16/26. Resident #1 was removed from his/her room prior to 10:00 AM and was able to return to his/her room between 3:00 PM and 4:00 PM. The DOH further indicated that Resident #1 did not attempt to re-enter the room at any time the room was being cleaned as housekeeping staff manned the door to prevent re-entry until safe to do so. Interview with NA #2 on 4/16/26 at 1:53 PM identified he/she assisted Resident #1 with toileting prior to lunch (documented at 11:11 AM) on 3/16/26 and brought Resident #1 to the bathroom located near the shower station as resident's were not to use other resident's bathrooms. NA #2 further indicated Resident #1 preferred to stay in his/her room and did not wander.Interview with the Assistant Director of Nursing (ADNS) on 4/17/26 at 2:45 PM identified the facility planned for Resident #1 to participate in activities from 10:00 AM to 11:30 AM on 3/16/26, return to the chair located outside of his/her room around 11:30 AM to be served lunch, and then return to participate in activities after lunch. 2a. Resident #1 was admitted to the facility in March of 2023 and had diagnoses which included dementia, schizoaffective disorder, depressive type, and adjustment disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 as severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 00), was dependent with bathing, required substantial assistance with toileting and personal hygiene, and was able to ambulate with supervision/touch assistance.The Resident Care Plan (RCP) dated 8/16/25 identified Resident #1 received psychotropic medication related to the diagnosis of dementia, depression, schizoaffective disorder, anxiety, and insomnia, and a history of refusal of care, paranoia/delusions, and hitting, and that he/she was a resident with a dementia diagnosis in a secured memory care unit related to behaviors that required staff intervention and redirection for safety as well as life enriching specialized dementia program. Interventions directed to monitor for depression as evidenced by refusal of care, hitting staff, paranoia, and delusions, and intervene and redirect when wandering, exit seeking, or when behaviors become intrusive or affect other residents. b. Resident #5 was admitted to the facility in October 2024 and had diagnoses which included vascular dementia, schizoaffective disorder, bipolar type, and unspecified head injury.The comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 as severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 00), was dependent with bathing, toileting, and personal hygiene, and able to ambulate independently. The Resident Care Plan (RCP) dated 8/18/25 identified Resident #5 had a diagnosis of dementia and was placed in a secured memory care unit related to behaviors that required staff intervention and redirection for safety as well as life enriching specialized dementia program. Interventions directed to intervene and redirect when wandering, exit seeking or when behaviors became intrusive or affected other residents.The Reportable Event Form dated 10/11/25 identified Resident #5 was struck in the face by another resident (Resident #1), and mild swelling was noted to the left of Resident #5's face.The hospital Discharge summary dated [DATE] identified Resident #5 was struck in the face by another resident, experienced no loss of consciousness, no nausea/vomiting, with minimal swelling present.Interview with LPN #1 on 4/16/26 at 9:59 PM identified he/she was the charge nurse on 10/11/25. LPN #1 identified Resident #5 had wandering behaviors, kept to his/herself and was non-verbal.Interview with NA #1 on 4/16/26 at 10:14 AM identified Resident #5 was observed walking down the hallway, on the side of Resident #1's room. As Resident #5 approached Resident #1's doorway, Resident #1 stepped out of the room and punched Resident #5 in the face, just under the eye. NA #1 indicated he/she instructed Resident #1 to return into his/her room, immediately removed Resident #5 from the area and informed LPN #1.Interview with the Assistant Director of Nurses (ADNS) on 4/17/26 at 2:05 PM identified Resident #1 was moved to a different room in a different area of the facility (from a secured wing to an unsecured wing) following the altercation with Resident #5.Interview with the Director of Nursing Services (DNS) on 4/16/26 at 4:10 PM identified the facility had zero tolerance for abuse of any kind. The Resident's Right to Freedom from Abuse, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Neglect, and Exploitation Policy and Procedure identified the facility's residents had the right to be free from abuse, neglect, misappropriation of property, and exploitation. Past Non-Compliance:The facility presented a corrective action plan dated 3/19/26 which included:-House-wide review of residents with cognitive impairment, wandering, intrusive behaviors, or history of aggression to ensure appropriate supervision levels and individualized interventions were in place.-Review and update of care plans as needed to reflect current risks and interventions, including supervision requirements, redirection strategies, behavioral monitoring, and environmental safety measures.-Re-education of all licensed nurses and direct care staff on resident-to-resident altercation prevention, abuse prevention, early identification of at-risk behaviors, supervision expectations, immediate intervention, timely reporting, notification requirements, documentation standards, and adherence to care plans. Staff were specifically instructed to redirect residents observed in proximity when risk was identified.-Director of Nursing to conduct audits of 3-5 residents identified as at risk for intrusive behaviors or altercations. Audits to occur weekly for four (4) weeks and monthly thereafter for two (2) months. Audit to include verification of accurate care plans, appropriate supervision, staff intervention and redirection, and proper documentation.-Results of audits to be reviewed through facility's QAPI program with identified concerns resulting in immediate corrective action, including staff re-education and increased monitoring. Compliance to be sustained through continued QAPI oversight.